MAINE BUREAU OF MOTOR VEHICLES
APPLICATION FOR DISABILITY PLATES/PLACARD

☐ BMV Entered

Please type or print legibly

☐ New Application
☐ Re-application

Removable Windshield Placard _____ **Special Designating Plates:** _____

Current Plate # _____

Applicant's Name_____ Registrant's Name_____

Address: _____ Address: _____

_____ Zip _____ _____ Zip _____

Date of Birth _____ Date of Birth _____

Telephone Number: _____

☑ ***Please provide a copy of your current registration for disability plate applications.***

BMV Use Only

Placard #_____

_____

Plate #_____

Issue Date: _____

Exp. Date: _____

Returned #:_____

Replaced #: _____

Issued by: _____

APPLICANT'S STATEMENT OF UNDERSTANDING

I understand that I may park in a disability parking space when the vehicle is occupied by the disabled person and the vehicle is properly displaying disability plates or a placard. I understand disability applications are valid for up to four (4) years and that I must reapply before the expiration date.

I understand that the Secretary of State may restrict or suspend my driver's license based on the information provided by my physician. With this understanding, I hereby give permission for my physician to release my medical history to the Secretary of State, Bureau of Motor Vehicles to determine my eligibility for a driver's license.

I may take this completed application to my nearest Motor Vehicle Branch Office or mail it to: Disability Clerk, Bureau of Motor Vehicles, 29 State House Station, Augusta, ME 04333-0029. If you have any questions, please call (207) 624-9000 extension 52149.

Applicant's Signature _____ Date _____

Altered forms will be returned to the applicant.

PHYSICIAN'S STATEMENT

Condition is: ☐Permanent (4 year maximum) ***(Please complete the reverse side of application.)***
☐Temporary for a period of _____ months (6 month maximum)

☐ Cannot walk two hundred feet without stopping to rest.

☐ Cannot walk without the use of, or assistance from: a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device.

☐ Is restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg of room air at rest.

☐ Uses portable oxygen.

☐ Has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

☐ Is severely limited in their ability to walk due to an arthritic, neurological, or orthopedic condition.

Name of Physician, Physician's Assistant or Nurse Practitioner (please type): _____

Signature: _____ Date: _____

Address: _____ Telephone: _____

_____ License Number _____

PS-18 Revised 9/01

CERTIFICATE OF EXAMINATION

For Permanent Conditions Only

FOR THE REPORTING PHYSICIAN:

1. This report is requested because the issue has been raised as to the possibility that this applicant may have a mental/physical condition that could affect his/her ability to drive a motor vehicle safely. Your report will be advisory and used to assist in determining eligibility for a driver's license. If you have any questions, please call the Medical Review Coordinator's office at (207) 624-9000 ext. 52124 Fax (207) 624-9319.

2. A physician acting in good faith is immune from any damages claimed as a result of the filing of a certificate of examination pursuant to 29-A MRSA Section 1258(6).

FUNCTIONAL ABILITY PROFILE

This form cannot be completed without reference to the Functional Ability Profiles Booklet.

DIAGNOSIS *(Please print or type)*	**PROFILE LEVEL** *This section must be completed, Check only one box per diagnosis.*						
	1.	2.	3.				4.
			A.	B.	C.	D.	
If COPD, needs O2 SATS	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐

Date of last examination (must be within the past year). _____

How long has the applicant been your patient? _____

☐ No Medications

Current prescribed medication(s) and side effects experienced at present: _____

Reliability in taking medications: _____

Date of last seizure or loss of consciousness: _____

PHYSICIAN'S COMMENTS

(Important -- please describe physical and/or cognitive deficits.)